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The Criminalisation of Medical Harm in the UK

"FRENCH LAW FROM A COMPARATIVE LAW PERSPECTIVE: FOR AN OVERHAUL OF MEDICAL CRIMINAL LAW?"

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Medical Manslaughter

The use of criminal law as a response to medical harm has been controversial in the UK. Historically, this has been limited to occasional manslaughter prosecutions of practitioners for their 'gross negligence.' Whilst the term negligence is a familiar civil law concept, the gloss of 'gross' suggests a higher degree of carelessness worthy of criminal punishment. However, precisely what is meant by gross remains somewhat unclear. The leading case is that of *R v Adomako* [1994] 3 All ER 79 where a locum anaesthetist lost his appeal against conviction after failing to spot a disconnected oxygen tube during a routine eye operation which caused the patient's death. Lord Mackay of Clashfern set out the following test of liability for manslaughter by gross negligence [at p. 86:]

In my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such breach of duty is established the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty *should be characterised as gross negligence and therefore as a crime.* This

will depend on the seriousness of the breach of duty committed by the defendant *in all the circumstances in which the defendant was placed when it occurred*. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that *it should be judged criminal*. (my emphasis)

To summarise, there are thus 4 elements to establishing manslaughter by gross negligence:

- (i) Duty of care
- (ii) Breach of that duty
- (iii) Causation
- (iv) Gross Negligence

This is a circular test in that negligence will be gross, and thus criminal, if the jury thinks that it ought to be criminal. So if a jury asked how negligent must the D have been for this to be criminal, the answer is 'so negligent as to deserve conviction for manslaughter.' However, this has been affirmed by the Court of Appeal in the case of *R v Misra and Srivastava* [2004] EWCA Crim 2375 and is regarded (by the judiciary) as compliant with Art 7 ECHR. Nevertheless, it remains an unduly vague concept that is incapable of objective measurement and consistent interpretation and is thus potentially unfair to those prosecuted (Quick 2006). Whilst there are other vague terms of criminal liability, the implications of such uncertainty are particularly serious in the context of homicide. Indeed, the imposition of manslaughter liability based on grossly negligent

conduct has long exercised legal philosophers. For example, Jerome Hall found this an 'inordinately troublesome' area (Hall 1972: 959). Hall was rejecting H. L. A. Hart's celebrated general theory of guilt in which he defended negligent criminal liability as part of a wider capacity theory of responsibility (Hart 1968: 147). For Hall, the imposition of such liability loses sight of the notion of blame, which should be the proper foundation of criminal law. In terms of contemporary criminal law scholarship, however, Hart's view finds support from leading criminal law commentators (Ashworth and Horder 2013: 181–85) and also the Law Commission, in their proposed formulation of 'killing by gross carelessness' (1996 and 2005). Some have argued that a test based on recklessness would be more appropriate and might decrease the risk of weak cases being prosecuted (Quick 2006).

Whilst such cases remain relatively rare (Brazier et al 2017), nevertheless, healthcare professionals fear the prospect of criminal prosecution and punishment. The conviction of Dr David Sellu on 5th November 2013 intensified such fears. The case against Dr Sellu, a 63-year-old colorectal surgeon working at a private hospital, was that he should have ordered a CT scan and operated sooner on a patient with a suspected perforated bowel who later died. The incarceration of Dr Sellu caused much consternation amongst the medical community, and prompted a group of colleagues to successfully campaign for his appeal (<http://davidsellu.org.uk/supporters/>). On the 15 November 2016 the Court of Appeal allowed the appeal on the grounds that the trial judge's direction did not permit the jury to 'understand how to approach their task of identifying the line that separates even serious or very serious mistakes or lapses, from conduct which ... was truly exceptionally bad and was such a departure from that standard [of a reasonably competent doctor] that it consequently amounted to being criminal (*Sellu v The Crown*

(2016) EWCA Crim 1716, para 152). This was connected to concerns that experts called by the prosecution were potentially usurping the role of the jury in appearing to determine the issue of 'gross negligence', an issue that has previously been identified as problematic in such cases (Quick 2011).

Supporters of Dr Sellu also argued that insufficient attention was given to the clinical context of care, with the trial judge regarding it as an aggravating factor that treatment took place in a private hospital. Mr Justice Nicol noted that Dr Sellu's negligence was not 'committed in the pressured circumstances of an acute NHS hospital where the stress of dealing with very many patients in an emergency condition can be particularly challenging' (*R v Sellu* 5 November 2013). However, unlike NHS hospitals, private hospitals are not prepared to deal with such emergencies in terms of having appropriate clinicians on call to carry out specialist tests and procedures. It was reported that an internal investigation at the hospital found that its procedures for dealing with emergencies that developed after routine operations were not robust enough to prevent a systemic failure, and that this evidence was not disclosed at Dr Sellu's trial. Such evidence is not only important in mitigating the culpability of individuals, but also raises the possibility of prosecuting organisations for serious systems failures.

Corporate Manslaughter

Criminal law has traditionally struggled with the idea and practicalities of prosecuting corporate entities, especially in terms of attributing responsibility (Wells 2001). However, manslaughter prosecutions against organisations have been possible

since 6 April 2008, under the Corporate Manslaughter and Corporate Homicide Act 2007. Under Section 1 of the Act, organisations will commit homicide if the way in which it manages or organises its activities both cause a death and amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased. In the case of healthcare organisations, there is little doubt that they will be under a duty of care towards patients; thus the key questions will, as with individual manslaughter liability, revolve around the grossness of the breach and to causation. Under Section 1(4) (b) a departure from the standard of care is gross if the conduct ‘falls far below what can reasonably be expected of the organisation in the circumstances’.

Maidstone and Tunbridge Wells NHS Trust was the first NHS organisation to be prosecuted for the offence of Corporate Manslaughter. This followed the death of a woman at Pembury Hospital, Tunbridge Wells, after undergoing an emergency caesarean section in 2012. The prosecution alleged that the trust caused the patient’s death by a gross breach of duty of care by failing to take reasonable care to ensure: (i) the anaesthetists involved held the appropriate qualifications and training and (ii) that there was an appropriate level of supervision for the anaesthetic treatment of the deceased. However, two weeks into the trial, the judge ruled that there was no case for the trust or the anaesthetist to answer and directed the jury to return not guilty verdicts (*The Guardian* 28 January 2016). We thus await the first conviction of an NHS organisation for corporate manslaughter, which is likely to remain a challenge (Wells 2013).

III Treatment or Wilful Neglect

Whilst the imposition of manslaughter liability has been widely criticised (McCall Smith 1993) the absence of a lesser offence for conduct causing harm short of death has long been questioned (Smith 1971). However, there are offences of ill-treating or wilfully neglecting patients, set out in Section 127 of the Mental Health Act 1983, Section 44 of the 2005 Mental Capacity Act, and Sections 20 and 21 of the Criminal Justice and Courts Act 2015. The 2015 offences apply to care workers and care providers. In order to be deemed a care worker for the purposes of the Act an individual must receive a salary for the care provided. This means that care provided by family and friends is not covered by this offence. Under Section 21, the liability of care providers (organisations) depends on determining that an individual has committed the care worker offence. These offences came into force on 13 April 2015 and have a maximum penalty of 5 years imprisonment or a fine (or both).

Controversially, Sections 20 and 21 are conduct crimes not requiring proof of actual harm. It is arguable that neglecting or ill-treating patients is in itself harmful and worthy of potential punishment, irrespective of the actual harm to patients in question. The absence of a harm requirement also has practical advantages in avoiding the problem of proving the fault element in relation to the harm. Inserting a harm requirement would have also encouraged unedifying arguments about whether the harm caused or risked was serious enough. It might also be said that clinicians and carers are already on notice that their patients are at risk. And the stronger the objective evidence of neglect, the

harder it will be for defendants to argue that they didn't foresee this. Despite the absence of a harm requirement, in practice, prosecutions are more likely to follow in cases where ill-treatment or wilful neglect has actually caused tangible physical harm.

Regulatory Offences

UK Criminal law also contains a large number of offences that have been broadly labelled as regulatory. Recent examples include the creation of a number of offences in relation to breaches of various regulations enforced by the Care Quality Commission (the health sector regulator). These are covered in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and The Health and Social Care Act 2008 (Registration and Regulated Activities) Regulations 2015. Whilst the CQC has generally sought compliance, nevertheless, breach of certain regulations may be prosecuted without the CQC first issuing a warning notice. These include regulations in relation to consent, acting on complaints, good governance, duty of candour and requirement to display performance assessments. A defence to these offences exists where registered persons took all reasonable steps and acted with due diligence. An additional three regulations allow for criminal prosecution, but only where the breach results in exposure to avoidable harm or significant risk of such harm occurring. These are 'safe care and treatment', 'safeguarding service users from abuse and improper treatment', and 'meeting nutritional and hydration needs'. Whilst there is no doubt that the criminalisation of these safety breaches is symbolically important, it is less clear whether they will be effective in terms protecting patient safety (Stirton 2017).

Criminalisation and Patient Safety?

Little is known about the relationship between criminal law and patient safety. To date, no research has examined how such prosecutions impact on the medical practice of those affected or on the policies of organisations. Does criminal law deter unsafe practices? Does it have a positive net effect on levels of safe care? These are difficult questions to answer, not least because there are different types of criminal offences and because the medico-legal and regulatory environment includes numerous mechanisms and influences on behaviour, making the task of isolating any effect of criminal offences difficult if not impossible. Nevertheless, the absence of hard evidence evaluating the *actual impact* of criminal prosecutions need not prevent discussion about the likely connection between criminal law mechanisms and the pursuit of patient safety. Criminal offences are not all the same and differ in terms of their design, implementation and their possible effect, including the effect they may have on efforts to improve patient safety. Whilst the use of criminal offences in this context has been dominated by concerns about accountability rather than deterrence, it would be premature to dismiss the possibility that the presence of criminal offences may help alter individual and organisational behaviour and thus play some role in securing safety. The deterrence argument needs to be carefully unpacked and considered in relation to specific offences. Deterring errors is difficult, given that genuine errors lead to the opposite of what an individual intended. But deterring intentional or reckless behaviour is a more realistic aim for criminal law. Likewise, organisational offences are more likely to lead to changes in policies and practices that can help improve safety.

In terms of manslaughter, the educative role of such prosecutions, on those prosecuted and to the profession generally is not well understood. Nevertheless, such

cases do have the capacity to assist with efforts to learn from safety failures. Whilst manslaughter cases essentially focus on individual fault, they can nevertheless allow high profile attention to be given to the context of fatal errors. The extent to which such lessons are learnt, both by the individual concerned and the wider medical community is not well understood. Perhaps the individual in question is less likely to repeat the same mistake again, but the extent to which this alters the behaviour of others is unknown. The fact that manslaughter prosecutions often tend to revolve around the same safety issue, for example, medication errors, might tend to suggest that such prosecutions have little effect in terms of learning and prevention. Whilst there is no direct evidence, some have speculated that criminal law not only fails to deter, but may in fact fuel a culture of secrecy and shame about errors (Ferner and McDowell 2013). However, whilst occasional manslaughter prosecutions are likely to offer little or no promise in terms of improving patient safety, there are reasons to be more optimistic about the other offences explored in this presentation.

Griffiths and Sanders are correct to note that the 'prosecution (or threat of prosecution) of a larger number of cases where there has been deliberate disregard or recklessness, as well as gross neglect, promises much more of a deterrent effect than the prosecution of a few cases' (2013: 154). Others have argued that such endangerment offences offer greater potential for a positive deterrent effect (Alghrani 2011). Whilst there is a lack of evidence to support this claim, nevertheless, a deterrent effect is more likely in the context of advertent as opposed to inadvertent harm. In particular, the offence in Section 21 of the Criminal Justice and Courts Act 2015, in targeting providers of care, should lead to greater attention to the implementation of policies that decrease the risk of patients being ill-treated or neglected. This could be related to safe levels of

staffing and increased monitoring of vulnerable patients for example. The threat of criminal prosecution should increase the pressure on organisations to have systems in place that minimise the risk of harmful outcomes. Ultimately, whether such offences actually have such an effect will depend on effective enforcement by the CQC and research that attempts to better understand the response of providers and professionals to such offences. Whilst criminal law is likely to play a minor role in the major task of improving safety, nevertheless, it would be wrong to dismiss it completely.

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